NHS
Health Education England

HEALTH EQUALITY TRAILBLAZER FELLOWSHIP PROJECT

Group Consultations as a Means of Reducing Health Inequalities: Our Experience Through the Lens of Education.

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BACKGROUND

The Scale of the Health Inequity Problem

Fair Society Healthy Lives – also known as The Marmot Review (Marmot, 2010)[1] highlighted that in England, people living in the poorest neighbourhoods die on average 7 years earlier than those who live in the most affluent areas. The difference in disability free life was 17 years. Ten years later a review (Marmot 2020)[2] highlighted things have been getting worse, not better. In the most deprived communities outside London, life expectancy fell and time in poor health increased. The Covid-19 pandemic has since exacerbated these inequalities.

The Kings Fund report[3], updated in August 2022 states that "Covid-19 mortality rates have been significantly higher in more deprived areas, causing a fall in life expectancy between 2019 and 2021 of almost 2 years for males and 1.4 years in females in the most deprived areas compared with 0.7 years for males and females in the least deprived areas." Mortality from Covid-19 is reported to be 1.5 higher in those with a learning disability compared to those without. People from some ethnic minority backgrounds experienced the highest Covid-19 mortality, including people from Bangladeshi, Pakistani and Black Caribbean groups.

Only 20% of health inequities are related to healthcare and the support it provides to people. The remaining 80% is related to social determinants of health. Marmot's 2020 report highlights multi-faceted social causes, with more people having insufficient money to live a healthy life and spending cuts such as closure of children's centres and cuts in the education system disproportionately affecting those already disadvantaged[2].

Marmot also highlights that the inequity challenges of one borough, town or community are vastly different to those in another; a challenge that primary care teams know only too well. This reinforces the need for flexible, responsive, localised models of care and support.

Long Term Conditions and Behavioural Change in Areas of Deprivation

The WHO Global Burden of Disease Report found that nine out of the top eleven causes of mortality globally are related to non-communicable diseases (NCDs). Specifically in the UK, the 2015 RCGP Health Inequalities report[4] highlights that areas of increased deprivation are more likely to have high prevalence of people living with multi-morbidities or long-term conditions and that, *"60 to 70 per cent of premature deaths are caused by behaviours that could be changed."* They conclude that, *"it is vital that patients are encouraged to become more involved in their own health and wellbeing."*

While acknowledging some social determinants cannot be changed by the individual, the 2010 Marmot report also advocates empowerment, stating:
"It is creating conditions for individuals to take control of their own lives. For some communities, this will mean removing structural barriers to participation, for others facilitating and developing capacity and capability through personal and community development"

Group Consultations and Communities Improve Clinical Outcomes

In the NHS world of 2022, resources are stretched, access limited, waiting times longer, workforce morale low and both the workload as well as the health inequality gap is expanding. Something about the way in which we work needs to change. Group consultations, or shared medical appointments are an alternative to 1:1 consultations for long term conditions, providing clinical management, patient education and peer support. They can be face to face or online[4]. They can create time and space for education and behavioural change and unlock the power of patients (both individually and as a group). Group consultations are effective in improving clinical outcomes and associated with positive patient and clinician experiences[4].

Group consultations are identified in the NHS Forward View (link)as one of the 'Ten High Impact Actions' for general practice to release capacity and reduce workload. They are being discussed as an essential part of the recovery from the Covid-19 pandemic. Group consultations themselves are not a new concept. In 1905, Joseph Prett was the undisputed pioneer of the group or 'class' method, for people who couldn't access the hospital, reported in the New England Journal of medicine as a great success in managing chronic disease[5]. In the UK, group consultations were initiated in 1939 with traumatised soldiers, where it was found that patients were managed better if moved from the couch to the circle, i.e., from the couch to the group.

Indeed, this concept has been used well before the pandemic. The publications 'Shared medical appointments, a promising response to escalating demands of healthcare', featured in the BMJ in 2017 along with 'Adopting innovations in care delivery – the case of shared medical appointments' in the NEJM[6]. They have been used at scale with evidence that they work across all ages in life including group antenatal care, children's developmental reviews, children's bladder and bowel care, diabetes and multi-morbidity[7]. The Cleveland clinic in the USA has been offering face to face shared medical consultations since 2010[8] with 160,000 shared clinic appointments showing patient satisfaction and clinical outcomes as good as, or better than, usual care. In response to the Covid pandemic, the clinic went from delivering <1% patient appointments virtually to >27% virtual appointments, converting into group video consultations.

Dame Prof Clare Gerada, who will be the new president of the RCGP this year, spoke about the unique role and power of the group consultations passionately, at the British society of lifestyle medicine conference in September 2022, where this option as a way of practice was a significant theme. Group consultations can promote the six pillars of lifestyle medicine: healthy eating, physical activity, managing stress, forming/maintaining good relationships, improving sleep and avoiding smoking and other harmful substances. These public health measures are embedded within Covid-19 guidance.

Group consultations can support community engagement and build social networks that reconnect people. The impact of engagement in cultural, community and natural assets on reducing inequality is well documented[9,10]. Poorer health in economically deprived communities can sometimes be offset by a strong sense of community and identity[10]. Culture, hobbies and community are important components to social determinants of health. A study conducted in a deprived community in London found that of those engaged in the arts, 82% enjoyed a greater sense of wellbeing, 79% ate more healthily and 77% engaged in more physical activity[11].

Primary Care Workforce Education to Support Our Patients Differently

So, in summary, we know group consultations work, that they improve patient and clinician satisfaction and can support clinical outcomes equal to or better than usual care. We know that the social determinants of health (and therefore behaviour and lifestyle factors) significantly impact health inequalities. Access to care and social opportunity have worsened through the pandemic and group consultations may be a way to re-build primary care stronger.

Marmot recommended that the medical profession could address health inequalities by assessing and improving:

- Workforce education
- Working with individuals and the community; seeing patients in a broader perspective
- Working in partnership.

This project focused on education of the wider primary care team on delivering group consultations – a different (but not new) way of consulting that sees clinicians supporting individuals within a group setting, building community and helping patients explore how to self-manage their condition in the context of their individual circumstances , in order to:

- Support **behavioural change** and empower individuals to take control of their own lives and health

- Build **community networks** of support to unique challenges in local communities, thus building resilience and empowering people to overcome local barriers to optimising health and wellbeing
- Embed an efficient, sustainable, progressive primary care consultation model that better supports **long term condition management** and has been shown to improve outcomes, increase patient knowledge, confidence and satisfaction, as well as supporting practitioner wellbeing and primary care team resilience.

INITIAL PROPOSAL

We initially proposed a project to investigate the educational impact of the introduction of Video Group Consultations (VGCs) into a practice or PCN to support patients with diabetes/pre-diabetes:

Implementing VGCs offers real time educational opportunities for different members of the primary care team including GP trainees, practice nurses, HCAs and ARRS roles such as Social Prescribers.

All members of the primary care team involved with group clinic delivery extend their knowledge and understanding of focus health conditions and by taking a patient-centred approach, discover and develop a deeper understanding of the reality of patients' lives and the challenges they face as they seek to take control of their health issues through group discussion. Making this change in practice involves developing leadership and change management skills across the whole team.

Group clinics also create opportunities for workforce development and improve integrated team working between administrators and clinical team members. As VGCs enable home working and are experienced as energising, they may also support clinician retention.

VGCs offer significant clinician time efficiencies and so the VGC model offers a novel and potentially sustainable way to address health inequalities that can be highly responsive to local challenges and empower patients to experience a consultation that is completely focused on what is important to them; share their collective wisdom and learning and develop wider social networks that are critical to community and personal resilience.

Group care offers the opportunity to motivate people and support behavioural change more fully, which may help patients succeed at reducing risk factors (such as smoking, obesity) that contribute to the excess morbidity and mortality.

Initial Proposal: The Process

To enable a full evaluation of the implementation process from an objective standpoint we planned to observe a team going through this journey rather than leading the change ourselves. We therefore planned to identify a number of sites (GP surgeries or PCNs) who were motivated to pilot VGCs to address inequalities who would develop a VGCs programme with a package of training provided by Redmoor Health ELC Partnership (www.redmoorelc.co.uk)

Throughout the change process, we planned to observe the educational impact, the effect on team working, and how the VGC care model may impact on health inequalities.
The comprehensive package of support, worth approx. £3,100 + VAT, would be fully funded for participating teams - see Appendix B for details of the support package. The participating practice or PCN would only need to free up staff to participate in training, planning and delivering the programme.

We suggested that the teams' initial VGC focus would be diabetes/pre-diabetes. There is a strong rationale of choosing this condition:

- Diabetes is a condition prevalent in the poorest communities
- Diabetes reviews represents a significant workload in primary care, and group clinics have the potential to reduce this workload
- There is already strong evidence to support the use of group clinics in diabetes, including studies that show that group clinics lead to greater reductions in HBA1c and blood pressure than one to one appointments and systematise care to align with QOF, which can increase QOF compliance by 18% within 12 months in diabetes in a deprived borough in London [12]

Once they have developed their VGC capability, the practice/PCN could use their knowledge and the toolkit they have developed to create group consultation programmes for other conditions, aligned with local population health needs and inequalities such as: hypertension, asthma, obesity, chronic pain, anxiety and depression, and support for families during early years.

Initial Proposal: Outcomes

While there is evidence relating to the patient outcomes with group consultations (including evidence that this approach can help to address health inequalities) and around practitioner experiences of VGCs there is a current lack of evidence around the educational impact this process has on clinicians and teams. We therefore were hoping to address this specific question in order to explore if this may be a useful approach to reduce health inequalities through wider education on, and implementation of, this model. We planned to seek advice regarding the most effective evaluation models to capture this learning. The hope was to be able to complete the project within 6-9 months allowing time for evaluation and presentation, for example to GP trainees who may then be encouraged to take on this approach in their training practices or future careers.

A further outcome would be that the practice(s)/PCN(s) involved will be able to demonstrate the impact of a group programme on clinical outcomes in those patients participating in the programme.

LEARNING: EVALUATION MODELS

The use of evidence-based practice is common within healthcare. It is well accepted, that the most robust evidence comes from randomised controlled trials (RCTs), because of their capacity to standardise conditions and reduce bias. "If all other things are equal, there is only one putative causal force acting on the intervention group"[13]. However, while the RCTs are indeed powerful tools, they only look at one outcome and the clinical spheres in which we work have more complex social interactions with many other factors involved for example, resource capacity, interpretations of stakeholders, organisational structure and cultural differences. Take an educational programme, for example, and ask the question "does it work"? The answer is that it depends on the context.

So, the RCTs can be used to ascertain whether an intervention is efficacious but there are no silver bullets, and in every context there are winners and losers. In 1997, Pawson and Tilley developed the Realist Evaluation school. They argued that in order to be useful for decision makers evaluations need not to answer 'does it work', but rather 'what works, how, in what conditions and for whom'[14]. What are the conditions and what are the caveats? The realist evaluation allows the evaluator to deconstruct the causal web of interactions.

Realist evaluation can help review the impact of interacting mechanisms which may promote or inhibit effectiveness of the intervention, thus understanding possible outcomes of the intervention in different contexts. However, one of the consequences of more realistic conception of what happens in the social arena of health care, is that the predictive claims are more modest than those of experimental science[13].

Realist Impact Evaluation has a particular focus on understanding why different outcomes are achieved in different contexts, therefore is particularly appropriate in this project, as it is often used for evaluating:

- New initiatives, pilot programmes and trials such as this
- Programmes that will be scaled out, to understand how to adapt the intervention in the new context[15]

Realist evaluation uses multiple types of evidence to look at multiple outcomes; there is no hierarchy of evidence. Realist evaluation must bring at least 3 forms of evidence together: qualitative, quantitative and comparative. In particular, in order to define the context, there needs to be a comparative approach. A realist approach has been described as 'not a method of evaluation but a way of thinking, so can be incorporated into any evaluation[16].

Realist evaluation starts with an initial programme, or the "CMO hypothesis" (Pawson and Tilley) which looks at the Context, Mechanism and Outcome of the intervention.

Context: This is found by comparison, finding a specific subgroup of people, with similarities and differences. They can be external or internal to the stakeholder

Mechanism: This looks at how the stakeholders interpreted the resources in their own mind

Outcome: Looks at multiple questions to be answered.

So, in a realist evaluation, you can evaluate that in this context, with this particular mechanism, these outcomes are generated. An example using our project might be that in a specific area in Hampshire (C), introducing video group consultations for diabetes (M), will reduce (or increase) barriers to accessing health care, contributing to reducing (or increasing) health inequality (O).

The types of questions asked might include ones like the following:

- For whom will this basic programme theory work, and not work, and why?
- In what contexts will this programme work and not work, and why?
- What are the main mechanisms by which we expect this programme to work?
- If the programme works, what outcomes will we see?

The next section discusses the barriers we have faced in effecting change in the primary care setting. As a summary of this section, and to highlight the concepts discussed above, Appendix A gives an example of how these challenges could be evaluated in a CMO format.

LEARNING: BARRIERS TO EFFECTING CHANGE WITHIN PRIMARY CARE

Our initial project aim was:
To evaluate the educational impact of a practice or PCN implementing Video Group Consultations for routine care of patients with Pre-diabetes/Type 2 Diabetes, with a specific focus on how this affects Health Inequalities.

We took our proposal (which detailed background about health Inequalities, possible benefits of Group Consultations and the proposed package of support) to practices/PCNs asking for their involvement, and to other organisations to source funding for the training (see Appendix B). We felt that the training needed to be fully funded for the participating practice/PCN teams as they would need to invest the time to engage in training and, with support, implement the approach with their patients. While the VGCs approach has the potential to release time once embedded it involves an investment of time at the start. Hence the need to "pump prime" the project with funding.

Recruiting sites

Both Ashly and Nichola were able to identify adopter sites early on. Nichola discussed the project with her contacts at The New Forest PCN, who were interested in becoming involved. Ashly spoke to her practice diabetes lead and practice manager who felt this was something they would like to undertake. At both sites they identified key individuals who had an interest in adopting this approach and who were in a position to be able to lead or influence on the decision.

Ruth took the proposal to her practice (in an area of relative deprivation) and PCN but due to lack of staffing capacity neither were able to progress the project. She then took the proposal to diabetic leads within other areas locally (via WISDOM diabetes educational meetings) using a pre-planned “elevator pitch” but unfortunately no adopter sites were found.

The main stated barriers were around finding staff time and energy to undertake the project. It was recognised that this may be a useful approach both for clinicians and for patients, but without a direct payment or incentive attached the practice/PCN did not feel able to get involved. The practices have cited staff shortages as a key factor in their inability to engage. It is known that practices in areas of higher deprivation run a greater list size per GP – a GP working in a practice serving the most deprived patients

will, on average, be responsible for the care of almost 10% more patients than a GP serving patients in more affluent areas[6]. This can result in increased staff burnout and difficulty with staff recruitment/retention. It is a "catch 22" situation that these are the very practices that may benefit most from an intervention that can improve patients' health and social capital while also improving efficiency, staff engagement and skill mix utilisation.

It is interesting that the practice in Frimley and the New Forest PCN, both of which have a relatively lower burden of socioeconomic deprivation, felt able to take on the project from the outset while practices/PCNs serving a more deprived population felt unable to take up the opportunity.

Securing Funding

Funding for the project was secured for the Frimley site as the CCG/ICS had a specific budget set aside for developing group consultations. Unfortunately, funding could not be secured for any Hampshire sites despite multiple attempts to access support via different funding streams e.g. PCN, CCG, ICS (Disease Prevention Lead, Diabetes Lead, Strategy and Transformation Team Lead, Primary Care Workforce Lead), HEE and AHSN. As funding was not available in Hampshire the New Forest PCN site project could not be progressed. This has highlighted that there is still a postcode lottery element to care – in Frimley the request was embraced, and funding offered quickly, while in Hampshire we have not been able to find support.

It is recognised that the NHS can be slow to adopt new innovations and models of care, taking an average of 17 years from inception to implementation. This is especially the case where there is no pharmaceutical backing to push through the change. Hampshire is promoting a pathway to adopt new drug treatments for cholesterol while not supporting other projects such as this to address lifestyle factors which contribute to chronic disease. Rates of lifestyle risk factors for chronic disease are higher in those patients affected by Health Inequalities so this lack of support to explore ways to address these factors may represent one way in which the system contributes to worsening Health Inequalities.

Outcomes

Frimley GP Practice

We were able to secure funding and an adopter site. The project progressed to the initial planning stages but unfortunately, due to a key member of staff leaving and a

planned practice merger, it was necessary to put the project on hold. The practice team hopes to implement the programme once staff have been recruited and the merger has been completed. This development highlights that many practices have little reserve in terms of staffing or capacity and new projects may stall when the focus needs to return to core services.

The New Forest PCN

Despite having an adopter site, we were unable to secure funding for the project so could not progress.

Andover

Although funding could not be secured for the original proposal, and the GP Practice and PCN initially felt unable to engage with the project due to the reasons above, a further opportunity has arisen. Within the PCN, estates e.g. GP premises and other suitable premises, are in short supply. An opportunity to pilot Group Consultations arose when there was a need to demonstrate valued utilistion of a site, in order to secure ongoing funding of that site. Details of the development and implementation of the programme are given in the following section.

Update December 2022

After attendance at the British Society of Lifestyle Medicine Conference in September Ruth sent out further emails to the organisations listed above, to seek funding and support for a project. A possible funding stream has been identified through a Personalised Care and reducing CVD budget. Ruth's practice in Andover has agreed to explore the possibility of a Group Consultations project around Lifestyle Medicine and a funding application has been put in. A connection has also been made with Gosport PCN with a hope to progress a similar project in that area. Both these sites are areas of relative deprivation within Hampshire so are good adopter sites to pilot this approach.

Appendix A looks to take these challenges and evaluate them from a realist evaluation perspective, looking at the specifics of the context, the mechanism and the outcome.

LEARNING: AN EXAMPLE OF INTRODUCING GROUP CONSULTATIONS INTO AN AREA OF RELATIVE DEPRIVATION

The challenges we have faced have helped us to recognise that in our initial proposal we took a "top down" approach. We identified what we saw as a need and how we thought that could be addressed, without first investing time to understand the views of, and pressures on, stakeholders and find out what would support them. In developing the Andover programme Ruth aimed to avoid this mistake and took a more collaborative approach.

Despite Andover PCN initially feeling unable to undertake a project around Group Consultations when the project subsequently had the potential to help secure funding/premises this presented an opportunity. Due to the previous groundwork in establishing an interested clinician and learning undertaken around the process of setting up Group Consultations, within a very short timeframe a plan was developed for a Face-to-Face Group Consultations programme to support patients living with overweight and obesity.

The patient group, length of programme and mode of delivery took into account local need and resources. Clinician experience and population health information (PHE Fingertips) were used to decide upon the target population. The length of programme was set as four sessions over eight weeks to allow time for change in measured parameters and include sessions for patient feedback. The programme also needed to be completed in time to show data to commissioners before a December deadline. Our research into some of the barriers for accessing services (including digital poverty), the lack of a training programme around virtual delivery and the need to demonstrate use of physical space dictated a face-to-face rather than virtual format.

Ruth worked closely with a PCN Care Co-ordinator to develop and deliver the programme. Details of the programme and how it aims to address Health Inequality can be seen in the HEAT analysis (appendix C). The limited funding meant that a training company/programme could not be used hence Ruth becoming more involved in the development of the programme than had been initially intended.

To be able to assess the service from a Realist Evaluation perspective we planned to gather both qualitative and quantitative data. Qualitative data included patient and practitioner experiences of the programme. Quantitative data included changes in physical parameters (BP and BMI scores) along with changes in the Patient Activation

Measure (PAM). It can take time for programmes to positively impact physical parameters and changes in the PAM can indicate early benefit from a programme before these translate into changes in physical parameters. We also assessed pre- and post-intervention practitioner satisfaction and understanding on Health Inequalities. At time of writing (Jan ‘23), due to illness, it has not yet been possible to analyse the collected data. This will form part of the work of the extension to the project and will inform the design and implementation of the next pilot.

SUMMARY OF OUR YEAR 2022-2023 AND NEXT STEPS

The last year has been a significant learning experience for us all. We started the year with limited knowledge and experience of working to reduce Health Inequalities and spent the initial few weeks to months understand the basics and context of health inequalities through reports, webinars and individual research. This learning, combined with our own interests led to the development of our project plan.

The finding of the RCGP Health Inequalities Report of 2015[4] that"60-70% of premature deaths are caused by behaviour that could be changed [and] it is vital that patients are encouraged to become more involved in their own health and wellbeing" combined with the conclusions of the Marmot Reports 2010, 2020[1,2] encouraged us to take a localised, responsive, Lifestyle Medicine based approach, focused on reducing risk factors for, and the impact of, non-communicable diseases

Additionally, in the NHS world of 2022, and even more so as we enter January 2023, the resources are stretched, access limited and waiting times longer. This is worst in the areas of highest need. Workforce morale is low, the workload is getting ever greater, there are increasing numbers of strikes within the NHS this winter and there is a recruitment and retention crisis.

With group consultations as one of the 'Ten high impact actions' for general practice, we hoped that education within the primary care team could:

- Support behavioural change and empower individuals
- Build community networks
- Contribute to an efficient, sustainable, progressive primary care model
- Improve patient knowledge and outcomes

BUT ALSO

- Support practitioner wellbeing and primary care team residence
- Reduce health inequalities by improving access and supporting behaviour change

With enthusiasm and a sense of purpose we set on the path of approaching different areas and PCNs. We found the education group of Redmoor and hoped to introduce this package to a number of PCNs. With this enthusiasm and progression, came the introduction to all the barriers and challenges described in the previous chapters. Through these, we have learnt of some of the challenges in implementing change within a structure like the NHS, especially at a time of significant pressures.

As the year has progressed, we have also moved from focusing on Video Group Consultations, to Group Consultations in general, keeping VGCs in mind as an option in the right context. We realised over the year that although at the start of 2022, in the context of the ongoing Covid pandemic, *video* group consultations were very valuable. As the UK has gradually reduced restrictions over 2022, and society is grateful for the

return to normal community life, patients are keen for more *face-to- face* interaction. VGCs still have a role in improving access for some parts of the population, but may also increase barriers for some patients, particularly those who are affected by digital poverty or who have communication challenges.

Through our CPD we have learnt more about the role of health coaching within a specific health coach setting, as well as part of normal traditional consultations. This learning has been energising and we have enjoyed sharing the approach with GP colleagues via a teaching session with New to Practice Fellows. We plan to continue further learning and development in this area and to use the techniques learned within our daily practice.

We have also spent time within the lifestyle medicine community and realised that group consultations really are high on the agenda for general practice. While in two of our three practices, we have physically been involved in some group consultations and shared medical consultation delivery, the implementation around education for the primary care team has not been successful so far within this project.

Our learnings have reinforced our drive to think differently about, and to continue to challenge, the traditional way in which we practice. We feel there is a need to:

1) Embed action on health inequality at the root of service design and ensure equitable access for all patients.
2) Improve education within the general practice team on delivering group consultations (and other novel approaches to care e.g. coaching) thus enabling teams to be able to offer the most beneficial style of consultation for each patient (i.e. personalised care)

The big question now is how to do this within the current over-stretched NHS primary care community.

In summary we can state our key learnings for this year as:

1) Change is hard: having support of your peers helps keep you motivated and on track.
2) Measuring success of an intervention is complex, realist evaluation is one example of how to do this and highlights the importance of personalised care and approaches.
3) The person at the centre of the problem ALSO has the solution. Don't rush into giving advice. Stay curious a little longer.

Where next in 2023?

Two out of three of us (NO, RD) will be extending this project for a further 6 months. We aim to:

- Re-visit funding options and hope to secure funding for one or two pilot sites.
- Set up group consultations in at least one site (Andover, Gosport, New Forest PCN).
- Evaluate impact on health inequality and educational impact of the intervention.

Appendix A:

Using Realist Evaluation Model to Review the Barriers within Primary Care: Contexts, Mechanism and Outcome for implementation of Group Consultations

Context	Mechanism	Outcome
No funding pot in Wessex area available readily for VGC training	Due to lack of official funding, difficult to convince CCG authorities to invest	Unable to secure funding to implement at CCG
Funding pot available in Frimley CCG for implementation of different consultation styles	Good communication from CCG staff who approved immediately.	Able to go ahead and begin staff training in the practice at Frimley CCG
Initial setting up admin for VGCs	Initial time investment to set up VGCs a barrier but good IT staff willing to do so.	IT staff and ractice willing and ready to set up
Key Staff disinterest in implementing VGCs	Lack of buy-in due to not enjoying the online/ video aspect due to low confidence in IT solutions/ tech and preference to face to face interaction. Personal health issues	Key staff member in Diabetes management. Without buy in from this member, unable to implement effectively as sees majority of diabetic patients at the practice.
Change in hosting practice's circumstance – upcoming big merger.	Asked for all ongoing big projects to be halted as practice now serving 30,000 patients	Project halted therefore unable to implement within initially set timeline.
Interest and buy in at PCN level	As it fits in with addressing health inequalities, the PCN were interested to support the project. Staff at another PCN also enthusiastic about the idea of group consultation	The PCN covers the two practices that have merged therefore the above outcome applied to this too. At another PCN, initial talks and were successful and group consultations commenced
Change from VGCs to GCs to reflect increased Face o Face	Andover PCN interested to use communal space effectively	Group consultations commenced due to staff enthusiasm and readily available space.

clinical interaction post COVID lockdowns.		

Appendix B

Funded package of support entails:

1. VGC basic training - £100 per person

VGC basic training is a highly interactive 2.5 hour action learning session for those who will be delivering VGCs and supporting delivery behind the scenes (clinicians, facilitators and clinic co-ordinators). Delivered as an interactive virtual learning session (recommend allocating 6 places).

2. Intensive support - £2,500 per team

This time will be used flexibly, in line with teams' needs and will be expected to cover at least the deliverables set out in the table below.

Deliverable	Description	Anticipated Outcome
Planning call with programme leads	ELC personal trainer runs an initial set up meeting with clinical led and practice manager to plan programme time line and run through the support on offer	Leaders are clear on the timetable and their responsibilities; they have their training codes and know who needs to be trained and by when
Team training	Attend 2.5 virtual learning session (national schedule; three times a month from September) delivered by Redmoor-ELC	All team members who need to be trained have been trained; the tem have minimal technical questions about the VGC process
Team planning and design workshop	ELC personal trainer prepares for, facilitates and follows up with local team to co-create a delivery plan for their first three VGCs and ensure the team is familiar with the VGC toolkit so they can prepare patient facing communications	The team have planned 12 steps to their first VGC and have scheduled dry run and first 3 VGCs in the clinic diary; the team is ready to start recruitment of patients for their first 3 VGC clinics
Dry run (1 week before live VGC)	ELC personal trainer supports the team to prepare for a dry run and demonstrates key aspects of the VGC e.g. gaining consent. Team practice VGC with staff acting as 'patients'	The team have gained confidence and are ready to go live

Observation or facilitation of 2 VGCs	Depending on team's needs, ELC personal trainer supports preparation for live VGC: reviews session planner (one per VGC); supports pre-VGC set up and briefing; observes team facilitating VGC and leads team improvement planning session held immediately afterwards, including completion of improvement plan	Three successful VGCs have been run
Handover and celebration session	ELC personal trainer prepares for and facilitates a handover session, including celebration of success	Team is ready to maintain momentum
Case study creation	ELC personal trainer works with team to create case studies	A case study is available to show the impact of VGCs in early adopter sites

Costings

Deliverable	Description	Anticipated Outcome	Cost
1. Team recruitment	Support to undertake recruitment; templates provided; advice on practice selection provided	Local lead has recruited enthusiastic teams as pioneers	£0

2. Basic VGC training	6 people	Participating teams and individuals are confident and: Understand the practicalities of gaining consent and managing IG risks in a VGC Know how to generate an invitation whilst preserving privacy and how to use video technology to run engaging, interactive VGCs Know how to deal positively with challenging group dynamics in a VGCs Know how to and have started to design a Results Board Have a personal plan to mobilise VGC	6 x £100 = £600
3. Intensive support for one PCN/practice	An intensive support programme to get teams going with VGCs	Teams are up and running with VGCs and have a plan to sustain the change	£2,500
		Total	£3,100

Redmoor ELC: www.redmoorelc.co.uk

Appendix C

ADVANTAGES AND CHALLENGES OF VIDEO GROUP CONSULTATIONS FOR HEALTH EQUITY

ADVANTAGES [17]

It is clear from the the report so far, that implementing group consultations, as well as the education for them presents challenges. Our initial proposal looked at video group consultations, rather than face to face. It is important to remind ourselves, of the advantages and challenges specific to the video group consultation (VGC) model, including in the context of health inequalities[17]. You can start to understand how there might be specific contexts and mechanisms where the outcome of a VGC could worsen or improve the health inequalities.

- Reduced barriers of travel and time
- Time and space for effective engagement
- Patients get more opportunities with clinician to get questions answered
- Embeds peer support
- Option for clinicians of all disciplines – leverages workforce capabilities
- Increases number of patients being seen
- Reducing repetition of normative advice reduces burn out of clinicians (may help sustain workforce)
- Seen during covid how the video can increase access in itself

CHALLENGES

Reported barriers of the Group Consultation model include the following:

- Signed waivers and adequate technical security needed for confidentiality and privacy for Video Group Consultations
- Difficulty reading body language if by VGC
- Renumeration for the work – Tarif assigned for GC? How going to be paid/cover the GP work?
- Space
- Difficult to assess the feasibility of scaling up – although there is an example through the Cleveland clinic
- Training at scale challenges, although can be conducted online

CLINICAL RISKS TO CONSIDER OF THE VIDEO GROUP CONSULTATION MODEL

- Confirming identity e.g. use of end of postcode or a password but hide email/surname etc

- Privacy – ensuring can't be overheard or if late, unable to join
- Knowing location of patients – in case disclosure of cause for concern
- Medical indemnity – cyber security insurance
- Confidentiality – only sharing needed info on results board
- Data protection – encrypted platform, reviewing cyber insurance etc

EXAMPLES OF BARRIERS TO VGCs THAT MAY AUGMENT HEALTH EQUITY

- Issues with private access to internet or device
- Language barriers
- Difficulty reading body language
- Lack of confidence or skills to use IT
- Fear of secutiy online
- Low literacy
- Hearing or visual impairment
- Learning difficulties
- Cognitive impairment

EXAMPLES OF WAYS TO REDUCE BARRIERS TO VGCs (Suggested by Future NHS Digital inclusion guide[19])

- Find access to cheaper laptops or support patients accessing video at practice
- Signpost those without skills/confidence to helpful resoruces
- Consider training facilitator to help people with online needs or do 1: 1 sessions with patients beforehand
- Consider running warm up online webinars
- Consider running group in native languages

Improving digital inclusion has been shown to reduce health inequalities and improve health outcomes. "11.9 million people in UK estimated to lack essential digital skills needed to make full use of online health services. Many of these people are likely to benefit most from VGCs but will not be able to access them without support."[19]
An example of the benefits of spending time integrating people into the digital world, and reducing inequality in access to the digital world, came through the NHS Widening Digital Participation Programme, which showed that during the 2017-2020 programme[20]

- 59% felt more confident using online health information
- 52% felt less lonely or isolated
- 21% had fewer visits to their GP for minor ailments
- 22% have progressed to booking GP appointments online and 20% to ordering prescriptions online

- 39% have saved time through carrying out health transactions online

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